The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-323-7268. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-323-7268 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** per person / **$1,200** per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care provided by a network provider, hearing care expenses, and facility expenses incurred for a knee or hip replacement at a Blue Distinction Center are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	Yes, **$250** for hospital review program non-compliance and **$150** for emergency room visits. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$2,500** per person / **$7,500** per family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-810-2583 for a list of network providers. For additional mental health/substance abuse network providers, see www.beaconhealthoptions.com or call Beacon Health Options at 1-800-332-2191.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	None.
	Specialist visit	20% coinsurance	30% coinsurance	None.
	Preventive care/screening/ immunization	No charge	30% coinsurance	Childhood immunizations are covered at 100% for network providers and out-of-network providers. No charge applies to the employee and spouse for the first $125 for a routine examination per year if the routine examination is performed by an out-of-network provider.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for first $150 per year, 20% coinsurance thereafter	No charge for first $150 per year, 30% coinsurance thereafter	The $150 benefit applies to employees and spouses only. Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Imaging (CT/PET scans, MRIs)	No charge for first $150 per year, 20% coinsurance thereafter	No charge for first $150 per year, 30% coinsurance thereafter	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com.	Generic drugs	20% coinsurance retail, $10 copayment mail order	20% coinsurance	Coverage is limited to 30-day supply retail and 31-90-day supply mail order. If generic substitution declined, you pay the difference in cost between the brand and generic equivalent.
	Preferred brand drugs	20% coinsurance retail, $20 copayment mail order	20% coinsurance	
	Non-preferred brand drugs	20% coinsurance retail, $35 copayment mail order	20% coinsurance	
	Specialty drugs	Generic: 10% coinsurance, $100 maximum copayment. Preferred brand: 20% coinsurance, $250 maximum copayment. Non-preferred brand: 20% coinsurance, no maximum copayment	Not covered	Use of the Specialty Pharmacy is required. Coverage is limited to 30-day supply. Variable copayment program / manufacturer assistance may apply if assistance program is available. Step therapy applies.

[* For more information about limitations and exceptions, see the plan or policy document at www.lineco.org.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Preauthorization and network providers are required for bariatric & TMJ surgery or services are not covered. Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	30% coinsurance	An additional $150 deductible applies. Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Emergency medical transportation	20% coinsurance	30% coinsurance	Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Urgent care	20% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	An additional $250 deductible applies if inpatient confinement not preauthorized. Preauthorization and network provider required for bariatric & TMJ surgery or services are not covered. Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Preauthorization and network provider required for bariatric & TMJ surgery or services are not covered. Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Fund Office.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance Primary networks are through Blue Cross Blue Shield and BeaconHealth Options	30% coinsurance	Preauthorization is required for inpatient services, residential services, partial inpatient and intensive outpatient treatment, and transcranial magnetic stimulation (TMS). An additional $250 deductible applies if inpatient confinement is not preauthorized.
	Inpatient services	20% coinsurance Primary networks are through Blue Cross Blue Shield and BeaconHealth Options	30% coinsurance	
If you are pregnant	Office visits	No charge	30% coinsurance	Maternity benefits are not provided for dependent children (other than prenatal visits).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at www.lineco.org.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Coverage is limited to 40 visits per year.
	Rehabilitation services	20% coinsurance	30% coinsurance	The allowable amount for speech therapy is $90 per visit, and the plan allows 50 visits per year maximum. Speech therapy for autism spectrum disorders not subject to the $90 allowable amount or 50 visit maximum.
	Habilitation services	Not covered	Not covered	None.
	Skilled nursing care	20% coinsurance	30% coinsurance	Coverage is limited to a 60-day annual maximum.
	Durable medical equipment	20% coinsurance	30% coinsurance	None.
	Hospice services	20% coinsurance	30% coinsurance	Coverage is limited to 180 days/lifetime.
If your child needs dental or eye care	Children's eye exam	The network provider is Vision Service Plan. The Plan provides covered exams and contracted eyewear.	Amount over $35	You pay for network provider upgrades.
	Children's glasses	The network provider is Vision Service Plan. The Plan provides covered exams and contracted eyewear.	Amount over $35 for frame and over $30 for lenses	You pay for network provider upgrades.
	Children's dental check-up	No charge	No charge	None.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Habilitation services, except for speech therapy for children for treatment of congenital medical defects and acute diseases, including hearing deficits caused by specifically diagnosed illnesses, cerebral palsy, and neurological disorders including autism
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

[* For more information about limitations and exceptions, see the plan or policy document at www.lineco.org.]

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture up to 12 visits per year	• Bariatric surgery if pre-certified (only one per lifetime and not covered for children)	• Chiropractic care at 50% coinsurance, subject to $600 annual maximum for all spinal manipulations/adjustments (and related services)
• Dental care (Adult)	• Hearing aids up to $2,500 (bilateral) every 5 years (every 2 years for children)	• Non-emergency care when traveling outside the U.S.
• Routine eye care (Adult)		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-800-323-7268 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-323-7268.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-323-7268.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-323-7268.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-323-7268.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.lineco.org.]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$400
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60*
The total Peg would pay is	**$2,560**

**Genetic tests are excluded.*

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$400
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20*
The total Joe would pay is	**$820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$400
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$550
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

The plan would be responsible for the other costs of these EXAMPLE covered services.